BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
ANDREW KEVIN SAJO, P.A.	)	Case No. 950-2013-000031
	)	
Physician Assistant License No. PA 16136,	)	OAH No. 2016080632
	)	
	)	
Respondent.	)	
	)	

DECISION REDUCING PENALTY

The attached Corrected Proposed Decision of the Administrative Law Judge is hereby accepted and adopted as the Decision of the Physician Assistant Board (Board) in the above-entitled matter, except that, pursuant to the provisions of Government Code Section 11517(c)(2)(B), the penalty is reduced as follows:

On page 38 of the Corrected Proposed Decision, the length of probation is reduced from five (5) years to three (3) years.

The Board adopts the balance of the Proposed Decision, including all terms and conditions of probation.

This Decision shall become effective on April 11, 2018.

DATED: March 12, 2018

ROBERT SACHS, P.A.
President
Physician Assistant Board

BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ANDREW KEVIN SAJO, P.A. Physician Assistant License No. PA16136, Respondent.	Case No. 950-2013-000031 OAH No. 2016080632

CORRECTED PROPOSED DECISION

Administrative Law Judge (ALJ), Carla L. Garrett, Office of Administrative Hearings, heard this matter on December 6, 7, 11, and 13, 2017, at Los Angeles, California.

Brian D. Bill, Deputy Attorney General, represented Complainant Glenn L. Mitchell, Jr., Executive Officer of the Physician Assistant Board (Board), Department of Consumer Affairs. Nicholas Jurkowitz, Attorney at Law, represented Andrew Kevin Sajo, P.A. (Respondent), who was present at hearing.

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on December 13, 2017.

During this ALJ's review of the exhibits in this matter, she noted that a number of documents contained confidential medical information, to wit, Exhibits 4, 6, 8, 9, 10, 13, 14, 15, 16, 17, 18, 19, 26, 27, F, G, H, J (page 2), and L. Redaction of the documents to obscure this information was not practicable and would not have provided adequate privacy protection. In order to protect the confidential medical information from disclosure to the public, this ALJ has issued a protective order placing the above-referenced exhibits under seal. Those documents shall remain under seal and shall not be opened, except as provided by the protective order, which has been marked as Exhibit 35. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517, may review the documents subject to the protective order, provided that such documents are protected from release to the public.

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FINDINGS OF FACT

1. Complainant made the Accusation in his official capacity as Executive Officer of the Board.

2. The Board issued Physician Assistant License No. PA16136 to Respondent on November 28, 2001. The license expired on February 28, 2017 and has not been renewed. Business and Professions Code section 3527, subdivision (g), provides that expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding or to render a decision suspending or revoking a license.

Investigation

3. On September 30, 2013, the Board received a letter dated September 26, 2013 from Purdue Pharma (Purdue), a pharmaceutical company, describing its Abuse and Diversion Detection (ADD) program. The letter stated that ADD was implemented to ensure that Purdue field-based personnel did not call on prescribers who engaged in what Purdue deemed as questionable prescribing practices. Purdue identified one of these prescribers as Respondent.

4. On January 6, 2014, the Board referred the matter to the Health Quality Investigation Unit of the Division of Investigation (Investigation Unit). The Investigation Unit reviewed Respondent's Controlled Substance Utilization Review and Evaluation System (CURES)[1] report for the period of November 26, 2010 through November 26, 2013, and identified two patients to whom Respondent had, in the Investigation Unit's estimation, overprescribed controlled substance medications: Patient LM and Patient GW.[2]

5. Respondent treated Patient LM and Patient GW at Perez Medical Clinic, where he worked as a physician assistant. Respondent began working at Perez Medical Clinic in 2012 through a temporary employment agency, and then was officially hired as a permanent employee by Yolanda Perez, the office manager of the clinic, in May 2013. Ms. Perez was the wife and widow of Dr. Oscar Perez, who founded Perez Medical Clinic. Respondent's supervising physicians were Dr. Jorge Galindo and Dr. Yanira Perez, who was the daughter of Dr. and Ms. Perez.

6. Respondent, Dr. Galindo, and Dr. Perez executed a Delegation of Services Agreement on May 10, 2013, which provided that Respondent would be supervised in accordance with the Physician Assistant Regulations, and that the physician would review,

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[1] CURES is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California. It serves the public health, regulatory oversight agencies, and law enforcement.

[2] Initials are used in lieu of patient names in order to protect the privacy of the patients.

countersign and date, within seven days the medical record of any patient treated by Respondent and who received prescriptions for Schedule II medications from him. The Delegation of Services Agreement also provided that the physician would audit the medical records of at least 10% of patients seen by Respondent under any protocols adopted by the supervising physician and Respondent. Additionally, the agreement provided that Respondent was to seek consultation with Dr. Galindo or Dr. Perez concerning patients who failed to respond to therapy. Respondent was authorized to write and sign prescriptions for Schedule II, III, IV, and V drugs without advanced approval because Respondent had earned his certificate of completion for a controlled substances education course on January 24, 2009.

A. UNDERCOVER OPERATION

7. On October 14, 2014, the Investigation Unit performed an undercover operation regarding Respondent's practices at Perez Medical Clinic. Specifically, an investigator, who wore a hidden video camera, posed as a patient named "Patient SF" and presented to Respondent with intermittent pain in his right shoulder due to exercise (i.e., lifting weights). The video of the Patient SF's encounter with Respondent is described in more detail below; however, the results of the undercover operation, which included Respondent, after performing a brief and incomplete examination, prescribing Norco to Patient SF pursuant to Patient SF's specific request, resulted in further investigation of Respondent's practices.

B. INTERVIEW OF RESPONDENT

8. On July 30, 2015, the Investigation Unit interviewed Respondent. During the interview, Respondent identified his supervising physicians as Drs. Galindo and Perez. Dr. Galindo worked all day on Mondays, Wednesdays, and Fridays, and Dr. Perez worked on Mondays and Fridays, until approximately 1:00 p.m., leaving Respondent as the only provider on Tuesdays, except on rare occasions. Respondent saw 30-40 patients per day. Respondent received no written protocols[3] or formularies[4] from Perez Medical Clinic, from Dr. Galindo, or Dr. Perez, regarding treating patients or prescribing pills or controlled substances. Instead, Respondent utilized the *Current Diagnosis Medical Treatment*, which was a textbook with general directions about managing different type of medical problems, and *Pharmacopoeia*, which was a textbook concerning pharmaceutical drugs. Additionally, if Respondent needed to discuss the treatment of a patient, he could contact Dr. Galindo or Dr. Perez by telephone, which occurred on an infrequent basis. No protocol or procedure

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[3] A protocol is the method or plan by which providers make healthcare decisions for patients.

[4] A formulary is a list of medications developed by the medical facility, in this case, Perez Medical Clinic, that Respondent, as a physician assistant, can prescribe without talking to the supervising physician first.

existed at Perez Medical Clinic requiring Respondent to check in with a supervising physician on a weekly or monthly basis to review medical records, discuss clinic issues, or to ask questions.

9. During the interview, Respondent explained that when seeing patients who suffered from pain, Respondent's customary practice included taking a detailed history regarding the specifics of the pain, and to inquire about past surgeries, past imaging, chronic pain medication, other medication, and more. Respondent stated he was judicial about the type of medicine he prescribed, because he did not want to overdose any patient, or cause any patient to become addicted. Perez Medical Clinic required no pain management contracts[5] with patients. Respondent stated that if a chronic pain patient reached a level requiring a pain management specialist, he would refer the patient to one. Beginning in 2013 or 2014, as a clinic-wide policy, chronic pain patients who received opioids such as Norco, received a reduction in their daily dosage from four times per day to three times per day.

10. Respondent resigned from the clinic in May 2015 to pursue other opportunities.

C. INTERVIEWS OF DRS. PEREZ AND GALINDO

11. On August 10, 2015, the Investigation Unit sent a letter to Yanira Perez, M.D., whose father founded Perez Medical Clinic, and where she worked as a physician on a part-time basis, and to Jorge Galindo, M.D., who worked at the clinic as a physician, requesting Perez Medical Clinic's signed written protocols and drug formularies. On September 12, 2015, Dr. Perez sent the Investigation Unit a letter in response, and stated that Perez Medical Clinic had no formulary list, but noted that some patients' insurance plans "usually ha[ve] an approved formulary that often determines what is covered for a given patient." (Exhibit 21, page AGO 739.)

12. On January 12, 2016, the Investigation Unit individually interviewed Dr. Perez, and Dr. Galindo.

13. Dr. Galindo confirmed that he seldom worked on the same days that Respondent worked at the clinic. Initially, Dr. Galindo reviewed and signed some of medical records drafted by Respondent, but over time, Dr. Galindo began trusting Respondent and elected to review and sign Respondent's medical records infrequently. Dr. Galindo confirmed that the clinic neither had any protocols for Respondent to use nor any formularies concerning the prescribing of narcotic medications. Dr. Galindo stated that Respondent would contact him if he had any questions or needed approval for a referral, and that he did so three or four times per month, typically by telephone. Dr. Galindo never cosigned any narcotic prescriptions written by Respondent.

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[5] A pain management contract is an agreement between the physician and the patient that details the potential risks of opioids, as well as the expectations to minimize those risks.

14. Dr. Perez confirmed that she and Dr. Galindo supervised Respondent, and that Respondent could contact her if he had any questions. Although Dr. Perez did not recall that Respondent ever called her to ask questions, she has, on a few occasions, addressed Respondent's questions in person concerning a couple of patients. Dr. Perez did not recall that she ever reviewed, audited, or countersigned any of Respondent's medical records. Dr. Perez confirmed that the clinic had no formulary for Respondent to use, and never discussed medications he could prescribe. Dr. Perez explained that Respondent was permitted to prescribe controlled substances, but Respondent needed a secondary signature. Dr. Perez never signed Respondent's prescriptions.

Medical Expert Review Report of Dr. Timothy A. Munzing

15. The Board obtained the medical records of Patients LM, GW, and SF. The Board retained Dr. Timothy A. Munzing to conduct a medical expert review of those records, including, but not limited to, the following records: CURES report for the period of November 26, 2010 to November 26, 2013; photocopies of prescriptions for Patients LM and GW; transcripts of the respective interviews of Respondent, Dr. Galindo, and Dr. Perez; transcript of the undercover operation concerning Patient SF; Delegation of Services document signed by Respondent and Drs. Galindo and Perez; and the September 12, 2015 letter from Dr. Perez. Dr. Munzing prepared a written report dated March 7, 2016 that outlined his findings.

16. Dr. Munzing, who testified at hearing, is a family medicine physician at Southern California Permanente Medical Group (Kaiser Permanente), and has served in that capacity since 1985. He earned his bachelor's degree in biochemistry from California State University at Fullerton in 1978, his doctor of medicine degree from the University of California at Los Angeles in 1982, and completed his internship and residency in family practice at Kaiser Permanente from 1982 to June 1985. Dr. Munzing has been certified since 1985 by the American Board of Family Practice and, since 1988, as a fellow by the American Academy of Family Physicians.

17. Dr. Munzing has been employed at Kaiser Permanente since 1985. He has served as a medical expert reviewer for the Medical Board of California (MBOC) since 2004, and as a medical expert reviewer consultant with the Drug Enforcement Administration (DEA) Tactical Diversion Squad since 2014. Dr. Munzing has reviewed approximately 125 cases for the MBOC and testified approximately 25 times in MBOC matters, and has reviewed approximately 25 DEA cases and testified six to eight times in federal and state courts in DEA matters. All of the DEA cases concerned allegations of overprescribing opioid medications.

18. Dr. Munzing currently sees patients two and one-half days per week, approximately 12 to 13 patients per half day, and uses the balance of his time to lead the residency program at Kaiser Permanente, which is discussed in more detail below. Over the course of Dr. Munzing's 32 years of practice, though not board certified in pain management, he has treated pain management patients, gone to trainings about pain

management, and presented lectures regarding prescribing opioids. Approximately 10 to 15 percent of his patients have experienced pain as a primary condition, and 30 to 40 percent of his patients suffer ongoing pain that is secondary to their diagnoses, such as arthritis.

19. Dr. Munzing has also served as Kaiser Permanente's program director for its residency program since 1988, and as its associate designated institutional official for graduate medical education since 2003. Dr. Munzing is one of 12 physicians who planned the Kaiser School of Medicine, which is scheduled to open in 2019 or 2020, depending on when the school can obtain its accreditation. Additionally, Dr. Munzing performs volunteer work at Kaiser Permanente's mobile medical clinic for the homeless. Dr. Munzing has seen thousands of patients over his career, and earned a number of awards and honors, including Kaiser Permanente's physician of the year in 2013. Dr. Munzing has also served as a clinical professor at the University of California, Irvine, since 2005.

20. Dr. Munzing authored a peer-reviewed article entitled *Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain,* which was published in the Permanente Journal on May 1, 2017. The article addresses the guidelines and the standard of care for prescribing opioids. Dr. Munzing has also given a number of lectures at medical conferences regarding the prescribing of opioids, as well as other medical topics.

A. PATIENT LM

21. Dr. Munzing reviewed Patient LM's medical records. He noted that Patient LM had been a patient at Perez Medical Clinic since 2004. Respondent treated her from June 15, 2012 through November 10, 2014, and saw her at 17 office visits. Patient LM, who was 56 years old at the time of the review, had a history of chronic knee pain, anxiety, hypertension, osteoarthritis, and chronic low back pain. According to his review of the medical records and prescription documents, Dr. Munzing found that Respondent prescribed Hydrocodone (to address pain) and Xanax (to address anxiety) to Patient LM on 16 occasions. Neither Dr. Galindo nor Dr. Perez countersigned any of the prescriptions written by Respondent to Patient LM.

22. Neither Dr. Galindo nor Dr. Perez countersigned any of the medical notes prepared by Respondent regarding Patient LM, despite language in the Delegation of Services agreement stating that Respondent would be supervised in accordance with the Physician Assistant Regulations, which require that the supervising physician would review, countersign, and date within seven days the medical record of any patient treated by Respondent and who received prescriptions for Schedule II medications from him.

23. Dr. Munzing's review of Respondent's notes revealed an overall failure of Respondent to chart pertinent information. Specifically, Dr. Munzing found that Respondent generally failed to include a history of Patient LM's present illness during Patient LM's visits with Respondent, and on those occasions when Respondent did chart the present illness, he failed to include any details about it. Often, Respondent failed to include any elaboration beyond the chief complaint recorded by the medical assistant, such as the specifics about the

pain and anxiety Patient LM suffered at any given visit (e.g., specific injury, specific past and current symptoms, functional limitations, if any, specific location, severity, neurologic changes, etc.), or other information warranting prescriptions for opioids. Additionally, Respondent generally failed to chart Patient LM's past medical history, past medications, evaluations (e.g., imaging and laboratory testing, etc.), and treatments (e.g., medication, physical therapy, non-medication treatments, consultations, etc.), during her visits.

24. Dr. Munzing found Respondent's progress notes extremely brief, "of no value in understanding the reason for the visit," particularly current and past diagnoses, and devoid of the rationale for prescribing controlled substances. (Exhibit 27, p. AGO 877.) Additionally, Respondent failed to appropriately document the examinations performed on Patient LM, especially in the area of the pain. For example, a knee examination would require observation for erythema (i.e., superficial reddening of the skin) and swelling, palpation, range of motion, tests for ligamentous and meniscal injury, and neurovascular testing. Respondent failed to document such an examination, despite Patient LM's chronic knee pain. Respondent's notes also generally lacked pain or functional scales, and any evidence of inquiry into behavioral, psychiatric, or addiction issues. His progress notes also generally lacked a specific diagnosis, a specific treatment plan, and specific goals, which Dr. Munzing explained "is needed at every visit." (Exhibit 27, p. AGO 878.)

25. Dr. Munzing also noted that Respondent's progress notes did not indicate whether he consulted CURES reports or performed any urine drug screens prior to starting Patient LM on any opioids, but Dr. Munzing acknowledged at hearing that state law does not currently require providers to obtain CURES reports before prescribing opioids; however, state law will soon implement such a requirement. Additionally, Respondent did not perform any medical monitoring with urine test screens, which Dr. Munzing explained "should be done on all patients taking large doses of controlled substances in order to evaluate for compliance, identify additional drugs in the patient (prescribed by others, illegal, etc.) that the prescribing provider is not aware of, etc." (Exhibit 27, p. AGO 878.) Dr. Munzing also stated that the progress notes lacked any evidence of medical monitoring through CURES reports, which "should be done on all patients taking combination does of opioids/benzodiazepines." (*Ibid.*)

26. Definitive examples of the failures outlined in Factual Findings 23 through 25 above, appear in Respondent's progress note dated November 10, 2014, where Respondent failed to include a history, and failed to include any information stating the severity of Patient LM's overall pain, knee pain, back pain, the kind of medication Patient LM had been taking, medication side effects, and whether Patient LM used drugs or alcohol. Respondent's examination notations, particularly concerning his examination of Patient LM's knee, lacked information indicating whether he observed any swelling or redness, whether Patient LM suffered any tenderness, Patient LM's range of motion, and a comparison between the bad knee and the good knee. The notes were silent concerning Patient LM's back pain and anxiety, and failed to indicate the severity of Patient LM's osteoarthritis associated with her knee. Additionally, some of the handwriting was illegible on the note, making it difficult to decipher Patient LM's diagnoses. Moreover, the note included no countersignature by the

supervising physician, no list of medications prescribed, and no indication of whether Respondent provided written consent to Patient LM regarding the dangers of narcotics. The only definitive things Dr. Munzing could glean from the November 10, 2014 progress note was that an x-ray revealed osteoarthritis, Patient LM was in no acute distress, her heart examination was normal, and pain existed in Patient LM's right knee.

27. More examples appeared in Respondent's progress note of September 16, 2014, where Respondent failed to include a history other than listing as a chief complaint that Patient LM was seeking medical refills and that she was complaining of a painful bump on the right leg. Respondent mentioned nothing about Patient LM's back or anxiety. Dr. Munzing found the note lacked evidence of a sufficient examination of Patient LM, particularly, the examination of the right knee, which included no information about the severity of the pain, whether any swelling existed, or whether the knee pain caused Patient LM to walk with a limp. Yet, Respondent listed diagnoses of "R knee pain x 1 week" which translated to "right knee pain for one week." Respondent also listed obesity, bronchitis, and another diagnosis that was indecipherable due to Respondent's handwriting illegibility. Respondent prescribed Norco, Xanex, Amlodipine, Lisinopril, Diclofenac, Hydrochlorothiazide, Pro Air inhaler, and aspirin, but the progress note was silent as to why Respondent prescribed those medications.[6]

28. At hearing, Dr. Munzing explained that records must be complete when dealing with a pain management patient, such that anybody looking at the records would know what is happening medically with a patient on a given date. While this task should be accomplished with all patient records, it is particularly important to have comprehensive medical records with pain management patients receiving opioid medications, given the patient safety issues involved.

29. Dr. Munzing explained that in reviewing the September 16, 2014 progress note, he concluded that Norco was not appropriately prescribed, because the history and examination listed minimal findings, and the note lacked any information suggesting that the pain was extreme enough to prescribe an opioid. The note also lacked information in the history or examination about bronchitis, and it included no countersignature by the supervising physician.

30. Dr. Munzing found failures similar to those found in the November 10, 2014 and September 16, 2014 progress notes in Respondent's progress notes of July 16, 2014, October 18, 2013, June 25, 2013, May 17, 2013, April 18, 2013, March 26, 2013, February

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[6] While Dr. Munzing also criticized this note for not listing medications, the progress note included a notation stating that the medications were listed on the left side of the chart. At hearing, Respondent testified that the records provided to the Board by Perez Medical Clinic did not include the left side of each of the charts, which typically included information regarding the patient's list of medications, medications that worked, medications that did not work, and authorizations for referrals to specialists.

7, 2013, December 17, 2012, November 15, 2012, October 12, 2012, and September 20, 2012.

31. From his review of the medical records, Dr. Munzing noted that in spite of ongoing treatment, Respondent never obtained imaging during his management of Patient LM until very late in his management, failed to obtain consultations from specialists, such as orthopedic physicians, pain management specialists, and physical therapists to address ongoing symptoms, and failed to document any discussions with Patient LM concerning the risks and benefits of controlled substances. Additionally, Respondent failed to note evidence of any discussion with Patient LM informing her that her dosage of opioids and benzodiazepines (i.e., Xanex) put her at higher risk for overdosing or dying. Dr. Munzing explained that benzodiazepines, which are potentially dangerous alone, are even more dangerous when combined with opioids, as they are both nervous system depressants.

32. Dr. Munzing received no information from the Board indicating that Patient LM suffered any complications at any time as a result of Respondent's treatment of her.

B. PATIENT GW

33. Dr. Munzing reviewed Patient GW's medical records. He noted that Patient GW had been a patient at Perez Medical Clinic since 2007, and his chart contained documentation as far back as October 29, 2012 indicating that Patient GW had been a patient of a methadone clinic. Dr. Munzing explained that methadone is a long-acting opioid medication that blocks the opioid receptor, therefore, if someone is on methadone and then takes more opioids, that person could die of an overdose. As such, Dr. Munzing explained that a physician should never prescribe an opioid to a methadone patient.

34. Respondent treated Patient GW from November 1, 2012 through September 2, 2014, and saw him at 13 office visits. Patient GW, who was 65 years old at the time of the review, had a history of chronic back pain, hypertension, hyperlipidemia (i.e., high cholesterol), tobacco smoking, depression, seizures, chronic pain stemming from a car accident in 2001, and discogenic disease (an age-related condition that describes deterioration if spinal disks). According to his review of the medical records and prescription documents, Dr. Munzing found that Respondent prescribed Hydrocodone, Klonopin, Soma, Ambien, and/or Dalmane to Patient GW on 13 occasions.[7] Neither Dr. Galindo nor Dr. Perez countersigned any of the prescriptions written by Respondent to Patient GW.

35. Neither Dr. Galindo nor Dr. Perez countersigned any of medical notes prepared by Respondent regarding Patient GW. Dr. Munzing reviewed Respondent's notes and found an overall failure of Respondent to chart pertinent information. Specifically, Dr.

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[7] Paragraph 18 of the Accusation states, in part, that Respondent also prescribed Diazepam and Lorazepam. Respondent denied prescribing those two drugs, and the record is silent regarding them.

Munzing found that Respondent generally failed to include a history of Patient GW's present illness at Patient GW's visits, and on those occasions when Respondent did chart the present illness, he failed to include any details about it. Often, Respondent failed to elaborate beyond the chief complaint recorded by the medical assistant, such as the specifics concerning the pain and seizure history Patient GW (e.g., specific injury, specific past and current symptoms, functional limitations, if any, specific location, severity, neurologic changes, etc.), or other information warranting prescriptions for opioids. Additionally, Respondent failed to chart Patient GW's past history, past medications, evaluations (e.g., imaging and laboratory testing, etc.), and treatments (e.g., medication, physical therapy, non-medication treatments, consultations, etc.), during his visits. Additionally, the notes included no current mental health status or mental health history.

36. Dr. Munzing found Respondent's progress notes extremely brief and "of no value in understanding the reason for the visit," particularly current and past diagnoses, and they were devoid of Respondent's rationale for prescribing controlled substances. (Exhibit 27, p. AGO 885.) Additionally, Respondent failed to document Patient GW's history at most visits, and failed to appropriately document the type of examination performed, especially in the area of the pain. For example, a back examination would require observation for erythema (i.e., superficial reddening of the skin) and swelling, palpation, range of motion, straight leg raising, and neurovascular testing. Yet, Respondent failed to document such a back examination, despite Patient GW's chronic back pain. Respondent's notes also generally lacked information regarding past laboratory testing, pain or functional scales, and any evidence of inquiry into behavioral, psychiatric, or addiction issues. The progress notes also generally lacked a specific diagnosis, a specific treatment plan, and specific goals, which Dr. Munzing reiterated "is needed at every visit." (Exhibit 27, p. AGO 886.)

37. Like with Patient LM, Dr. Munzing noted that Respondent's progress notes concerning Patient GW failed to indicate whether he consulted CURES reports or performed any urine drug screens prior to starting or continuing Patient GW on any opioids, but again acknowledged at hearing that state law does not currently require providers to obtain CURES reports before prescribing opioids. Like with Patient LM, Respondent did not perform any medical monitoring with urine test screens, which Dr. Munzing reiterated "should be done on all patients taking large doses of opioids/controlled substances in order to evaluate for compliance, identify additional drugs in the patient (prescribed by others, illegal, etc.) that the prescribing provider is not aware of, etc." (Exhibit 27, p. AGO 886.) Dr. Munzing also stated that the progress notes lacked any evidence of medical monitoring through CURES reports, which "should be done on all patients taking combination does of opioids/benzodiazepines." (*Ibid.*)

38. Definitive examples of the failures outlined in Factual Findings 35 through 37 appear in Respondent's progress note dated September 2, 2014, where Respondent failed to include a history, and present any evidence of performing a physical examination of Patient GW, such as muscular skeletal, neurological, or mental health examinations, other than notations indicating Respondent examined Patient GW's lungs and heart. Despite Patient GW's history of seizures, Respondent's progress notes lacked any information about the

seizures, such as the type of seizures from which Patient GW suffered, and the last time he suffered a seizure. At some point prior to this visit, Patient GW had been diagnosed with anxiety and depression, but Respondent's progress note on this date failed to include any history concerning Patient GW's anxiety or depression. Specifically, the note lacked information concerning how long Patient GW had been experiencing anxiety and depression, how they had manifested themselves, the reason Patient GW was suffering anxiety and depression, how severe were they, or any updated information about the status of his anxiety and depression. Additionally, Respondent noted diagnoses of hypertension, hyperlipidemia, tobacco smoke, and chronic back pain, but included nothing indicating whether Patient GW was getting better, worse, or remaining the same.

39. The September 2, 2014 progress note also indicated that Patient GW was taking Soma, Klonopin, Lisinopril, and Norco. Respondent prescribed refills of Soma, Klonopin, and Norco, but indicated nothing in the progress notes indicating that he was going to prescribe more of these medications, what diagnosis each medication was expected to address, and stated nothing indicating why the refills were warranted. Moreover, the note included no countersignature by the supervising physician, no list of medications prescribed, and no indication of whether Respondent provided written consent to Patient GW regarding the dangers of narcotics. Additionally, the progress note mentioned nothing about other modalities to treat Patient GW's pain, such as physical therapy, acupuncture, or acupressure, and nothing mentioned about referring Patient GW to a pain specialist.

40. More examples of Respondent's poor documentation appeared in Respondent's progress note of November 1, 2012, where Respondent failed to include an adequate history, even though just a few days prior on October 29, 2012, documentation appeared in Patient GW's chart indicating that Patient GW was a patient of a methadone clinic. The progress note lacked any indication that Respondent performed a sufficient examination, as a large portion of the notes was illegible, and there appeared to be no range of motion examination of Patient GW's back, no examination of his senses, and no examination of his reflexes. The note mentioned nothing about seizures or anxiety, or the status of his depression or chronic back pain. Respondent prescribed Soma, Klonodin, and Vicodin, but the note lacked any information justifying the need for those drugs. The note included no countersignature by the supervising physician, no list of medications prescribed, and no indication of whether Respondent provided written consent to Patient GW or had a discussion regarding the dangers of narcotics.

41. Failures similar to those found in the September 2, 2014 and November 1, 2012 progress notes existed in Respondent's progress notes of July 3, 2014, April 8, 2014, February 10, 2014, December 12, 2013, October 17, 2013, September 12, 2013, June 21, 2013, April 22, 2013, January 24, 2013, and December 20, 2012.

42. From his review of the medical records, Dr. Munzing noted that in spite of ongoing treatment, Respondent never obtained imaging during his management of Patient GW until very late in his management, failed to obtain consultations from specialists, such as orthopedic physicians, pain management specialists, and physical therapists, to address

ongoing symptoms, and failed to document any discussions with Patient GW concerning the risks and benefits of controlled substances. Additionally, Respondent failed to note any discussion with Patient GW informing him that his dosage of opioids and benzodiazepines (i.e., Klonopin) put him at higher risk for overdosing or dying. Dr. Munzing explained that benzodiazepines, which are potentially dangerous alone, are even more dangerous when combined with opioids, as they are both central nervous system depressants.

43. Dr. Munzing received no information from the Board indicating that Patient GW suffered any complications at any time as a result of Respondent's treatment of her.

C. PATIENT SF (UNDERCOVER OPERATION)

44. Dr. Munzing reviewed Patient SF's medical records prepared by Respondent and reviewed the video of Patient SF's only visit to the clinic to obtain a complete physical examination and to address his one-month long old pain in his right shoulder. The video depicted Respondent entering the examination room, introducing himself, and immediately questioning Patient SF regarding chest pain, palpitations, asthma, and smoking, followed by Respondent's examination of Patient SF's hearts, lungs, and pharynx. Patient SF told Respondent that he was suffering from shoulder pain, which he believed was caused by working out. Patient SF then told Respondent that a friend at the gym had given him some Norco for the pain and it helped. Respondent did not comment about the illegality of this act. When Patient SF told Respondent that Tylenol did not help him and asked Respondent to prescribe Norco, Respondent told Patient SF that he could give it to him, but that Norco was a narcotic and could be addictive. Respondent also ordered Patient SF to get a MRI, as well as laboratory work.

45. The video did not show whether Respondent performed a shoulder examination, and the audio of the video did not reveal whether Respondent had performed a shoulder examination either. If there was any impression in the audio that Respondent had performed a shoulder examination, Dr. Munzing found that it would have been brief in nature and insufficient to warrant a prescription for Norco. Respondent was in the examination room with Patient SF for a total of seven minutes.

46. Thereafter, before Patient SF left the clinic, Respondent told Patient SF that he had elevated blood pressure, and advised Patient SF that he would start Patient SF on hypertension medication. Patient SF picked up his prescriptions (a 30-day supply of Norco to address Patient SF's "pain" and a 30-day supply of Lisinopril to address his hypertension), as well as the orders to obtain a MRI and lab work.

47. Neither Dr. Galindo nor Dr. Perez countersigned any of the prescriptions written by Respondent to Patient SF.

D. STANDARD OF CARE

48. Dr. Munzing explained that the standard of care is the floor or the minimum amount of care medical professionals must provide. While most practices, including his at Kaiser Permanente, far exceed the minimum, Dr. Munzing applied only the minimum standard of care requirements during his review of Respondent's records and actions concerning Patients LM, GW, and SF.

49. Dr. Munzing explained that with respect to prescribing controlled substance medications, the standard of care requires that the provider's practice substantially comply with the guidelines published by the Medical Board of California, World Health Organization, and other key pain management organizations. In addition, the physician must follow applicable State and Federal laws regulating the prescribing of controlled substances. Dr. Munzing further explained that the major elements of these guidelines and laws basically align with each other. Dr. Munzing stated that "[w]hen used for medically legitimate purposes, physicians must weigh the potential risks with the potential benefits, making efforts to use less risky alternative when available." (Exhibit 27, p. AGO 901.) Dr. Munzing further stated that "the management goal needs to be to optimize the patient's function/ability and manage (not necessarily eliminate) pain, while always working at minimizing risks to the patient as best possible." (*Ibid.*) Such a goal requires frequent ongoing monitoring with the goal of lowering or eliminating opioids and controlled substance medications whenever possible. Additionally, Dr. Munzing explained that physicians "must always be vigilant about the possibility of overuse/abuse/diversion at every visit and refill, even in one's long-time, most trusted patients." (*Id.*)

50. Dr. Munzing also explained that physicians prescribing opioids and controlled substances must be aware of and on the look-out for red flags of abuse and diversion, such as patients (1) seeking early refills; (2) claiming that the medications were lost or stolen; (3) using multiple pharmacies; (4) using multiple pharmacies concurrently, or using long-distance pharmacies without a reasonable explanation; (5) obtaining controlled substances from multiple physicians (unless good documentation exists demonstrating that the physicians are working together in a unified effort to manage the patient); (6) obtaining or buying controlled substances from family, friends, or others; (7) giving or selling controlled substances to family, friends, or others; (8) using or abusing alcohol; (9) using tetrahydrocannabinol (THC)/marijuana, even with a marijuana card; (10) using drug culture street lingo for the names of medications or other drugs; and (11) patients with CURES reports and/or urine drug screens that reveal unexpected results. Given these factors, Dr. Munzing emphasized how important it was that physicians "trust (their patients), but verify." (Exhibit 27, p. AGO 902.)

51. Dr. Munzing also noted prescribing specifics outlined by the Medical Board of California: (1) taking a medical history and conducting a physical examination, including obtaining an assessment of pain, physical and psychological function, substance abuse history, history of prior pain treatment, an assessment of underlying or co-existing diseases or conditions, and documentation of the presence of a recognized medical indication for the

use of a controlled substance; (2) creating a treatment plan, including objectives; (3) obtaining informed consent demonstrating that the provider has discussed with the patient the risks and benefits of using controlled substances; (4) periodically reviewing the course of pain treatment; (5) referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives; and (6) keeping accurate and complete records that includes the medical history, physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

52. Dr. Munzing also explained that the standard of care concerning the evaluation and management of anxiety of a patient requires the provider to take an appropriate history to attempt to identify the severity, possible specific diagnosis or alternative diagnoses with similar symptoms, perform an appropriate examination, and to consider laboratory testing. The history should identify specifics about the feelings of anxiety, including the length of the symptoms (i.e., when did they start and whether they were related to any particular life event), severity, timing (i.e., how often and how long each episode lasts), associated symptoms (e.g., mania, depression, suicidal ideation, etc.). The history should also include other medical problems, a list of medications, including over-the-counter medications, and whether the patient uses drugs or alcohol. Additionally, an appropriate examination should include exploring the cardiorespiratory system, the thyroid to check for hyperthyroidism which can cause symptoms similar to anxiety, and the gastrointestinal, vascular, and neurological systems.

E. CONCLUSIONS REGARDING PATIENTS LM, GW, AND SF

53. Dr. Munzing found to a reasonable degree of certainty that Respondent's prescribing of opioids/controlled substances to Patients LM, GW, and SF deviated from the usual course of professional medical practice. Dr. Munzing concluded that none of the controlled substance and opioid subscriptions was medically legitimate and each was an extreme departure from the standard of care. Dr. Munzing found that Respondent's prescriptions and clinical management was excessive, and put Patients LM, GW, and SF at high risk for harm, such as overdose and/or death.

54. Specifically, Dr. Munzing concluded that Respondent's failure to document adequate and appropriate histories in the progress notes/records, as well as document adequate physical examinations, prior to prescribing and/or refilling controlled substances, combined with his failure to document any discussion with Patients LM, GW, and SF about the potential risks of controlled substances, constituted an extreme departure from the standard of care.

55. Dr. Munzing also concluded that Respondent, in prescribing opioids/controlled substances, failed to include in his progress notes a treatment plan, a discussion of treatment goals, a functional assessment, and ongoing monitoring. Dr. Munzing characterized these failures as an extreme departure from the standard of care.

56. Dr. Munzing concluded that Respondent's apparent failure to discuss the major potential risks of controlled substances with Patients LM, GW, and SF, evidenced by the lack of documentation in the progress notes/records of the same, constituted an extreme departure from the standard of care, especially given his prescribing of many dangerous prescriptions on a frequent basis for an extended period of time, including the combination of opioid and benzodiazepine medications (i.e., Xanex). Dr. Munzing explained that benzodiazepines, which are potentially dangerous alone, and even more dangerous when combined with opioids, as they are both central nervous system depressants.

57. Dr. Munzing also concluded that Respondent's prescribing of opioids/controlled substance medications to Patients LM, GW, and SF without medical justification, evidenced by the lack of documentation in the progress notes/records of the same, constituted an extreme departure from the standard of care.

58. Dr. Munzing concluded that Respondent's failure to perform and document the necessary monitoring while prescribing dangerous opioids/controlled substance medications on a frequent basis for an extended period of time constituted an extreme departure from the standard of care. A thorough history, updated history, and appropriate examination were required at every visit when prescribing dangerous medications, which did not occur during Respondent's treatment of Patients LM and GW.

59. Dr. Munzing concluded from his review of the records that there was a significant failure to provide and ensure appropriate supervision and review of Respondent's treatment of Patients LM, GW, and SF. Dr. Munzing found that especially troubling because Patients LM, GW, and SF were receiving dangerous medications in an environment with minimal to no evaluation, monitoring, and documentation. Dr. Munzing concluded the failure to provide and ensure appropriate supervision was an extreme departure from the standard of care.

60. Dr. Munzing also concluded that Respondent failed to appropriately evaluate and manage Patient LM's anxiety. Specifically, Respondent treated Patient LM, who had been receiving Xanex for a long period of time, without any appropriate evaluation to confirm the diagnosis. Dr. Munzing concluded that Respondent's failure to appropriately evaluate and manage Patient LM's anxiety, and his repeated prescribing of benzodiazepines (i.e., Xanex), constituted an extreme departure from the standard of care, given the fact that benzodiazepines are potentially dangerous alone, and even more dangerous when combined with opioids, as they are both central nervous system depressants.

61. Dr. Munzing also concluded that, with respect to Patient GW who at one time was a patient of a methadone clinic, Respondent was required to take special care when prescribing and/or administering a narcotic controlled substance to a "known addict." Specifically, Respondent was required to perform an appropriate prior examination, identify a medical indication, keep accurate and complete medical records, including treatments, medications, periodic reviews of treatment plans, and provide ongoing and follow-up medical care as appropriate and necessary. Additionally, Dr. Munzing explained that the

provider should be willing to refer such patients for additional evaluation and treatment, particularly for individuals at risk for misusing their medications, and to recognize that patients with a past substance abuse history require extra care, monitoring, documentation, and consultation with addiction medicine specialists. Finally, Dr. Munzing explained that the provider must maintain accurate and complete records, as prescribing opioids to an addict for legitimate medical reasons is only done with intense monitoring, evaluation and re-evaluation, consultation by appropriate subspecialists, and very thorough documentation. Dr. Munzing found that Respondent's failure to adhere to these factors when prescribing Klonopin and Soma to Patient GW who Dr. Munzing believed to be a drug addict, constituted an extreme departure from the standard of care.

62. Dr. Munzing also concluded with respect to Patient SF, who presented with an elevated blood pressure at the time of the visit, Respondent was required to recheck and confirmed Patient SF's blood pressure. Additionally, in order to properly evaluate Patient SF's blood pressure, Respondent should have taken Patient SF's history about past blood pressure elevations, family history, history of alcohol, smoking, caffeine, and salt intake, and he should have performed an examination that focused on the cardiovascular system, and explored possible organ damage. Dr. Munzing also explained that Respondent should have ordered laboratory testing concerning Patient SF's electrolytes, serum creatinine, fasting glucose, HgbA1c, lipid profile, urinalysis, and electrocardiogram. He also stated that for modest elevations in blood pressure in patients, non-pharmacologic measures should be considered before prescribing any medication, such as imposing salt dietary restrictions, exercising, limiting alcohol intake, and requiring patients to lose weight and stop smoking. Here, Respondent saw Patient SF for one visit, failed to take an appropriate history and examination, and when discovering that Patient SF's blood pressure was elevated, did not repeat a blood pressure check of Patient SF, but took Patient SF's blood pressure only once. As such, Dr. Munzing found Respondent's evaluation of Patient SF's blood pressure inappropriate. Dr. Munzing found that Respondent's overall failure to appropriately evaluate and manage Patient SF's elevated blood pressure was a simple departure from the standard of care.

Respondent's Expert Testimony

63. Respondent, who testified at hearing, served as an expert witness in these proceedings. Respondent graduated from California State University at Long Beach in 1991 with a Bachelor of Science degree in biochemistry, and in 1999 with a Master of Science degree in biology. In 1999, Respondent authored his master's thesis, *Light-Dependent Phosphorylation of Rhodopsin in a Reconstituted System.* In 1999, Respondent co-authored a paper entitled *SV40 VP1 Assembles into Disulfide-Linked Postpentameric Complexes in Cell-Free Lysates.*

64. Respondent completed a physician assistant program at Western University of Health Sciences in 2001, and obtained his physician assistant certificate. He completed a controlled substances education course on January 24, 2009, earning him certification to write prescriptions for narcotics. Beginning in 2001, Respondent served as a physician

assistant in medical facilities focusing on family practice, emergency medicine, urgent care, occupational medicine, and weight loss, and has seen anywhere from 40,000 to 60,000 patients over the span of his 10-plus years as a physician assistant. Specifically, Respondent has managed hypertension, hyperlipidemia, diabetes, chronic obstructive pulmonary disease, asthma, abdominal pain, thyroid conditions, chronic pain, acute illnesses, injuries, and more, at a minimum of 11 medical facilities over the years, including emergency room settings. Respondent has not worked as a physician assistant since he left the employ of Perez Medical Clinic in May 2015. He is currently a grocery store employee.

65. Respondent has reviewed and prepared many medical records since 2001, and explained at hearing that the standard of care regarding medical records is that they must contain sufficient information for the medical provider to "know what is going on with the patient." Respondent also explained that it is important to follow protocols when treating patients, and not venture outside of the scope of practice of the supervising physician. Respondent defined formularies as medical guidelines for prescriptions for specific patients, and said they could come in several forms, such as from *Pharmacopoeia* and from the list of drugs issued by insurance companies outlining the medications they would agree to pay.

A. PATIENT LM

66. Respondent first began treating Patient LM on June 15, 2012, but she had been a patient of Perez Medical Clinic since 2002. Respondent understood from previous charts that Patient LM had been suffering chronic knee pain and had been prescribed Vicodin. Respondent explained that he believed that Patient LM's chronic knee pain was due, in part, to her morbid obesity. Respondent contended that, despite Dr. Munzing's conclusion to the contrary, his June 15, 2012 progress note was sufficient because he stated in the note that he conducted an extremities examination, which revealed that Patient LM's right knee had a decreased range of motion. Additionally, the note indicated that he performed an examination of Patient LM's back, and stated that it was "+ TTP", which meant "positive tenderness to palpation." Respondent explained at hearing that he always performed examinations of his patients, and if he found anything abnormal, he documented it. In the June 15, 2012 progress note, Respondent also stated that he had referred Patient LM for a MRI concerning her knee and a bone density test regarding an osteoporosis diagnosis he had given her. Additionally, he wrote that he was prescribing Vicodin to address her chronic lower back pain, and Xanex to address her anxiety.

67. However, Respondent acknowledged at hearing that he did not include in his June 15, 2012 note how the range of motion limited Patient LM's knee movement. Additionally, he did not include the current status of Patient LM's back issues, which he acknowledged was important to know before prescribing controlled substances. Additionally, Respondent acknowledged that his note was silent on whether he had a conversation with Patient LM regarding her anxiety, the level of her anxiety, and the date of her last panic attack. Also, during the hearing, the June 15, 2012 progress note necessitated translation by Respondent of some his handwriting due to illegibility. Despite these factors, Respondent contended that his June 15, 2012 progress notes were in compliance with the

standard of care, because another physician could review his notes and understand "what was going on" with Patient LM. Moreover, Respondent stated that even though his notes did not indicate how Patient LM's medications impacted her daily functioning, one could infer that the medication was working because there was nothing in the notes indicating that her daily functioning was worsening.

68. Respondent explained at hearing that a medical provider evaluation note of June 29, 2004, written by Dr. Oscar Perez, showed that he had diagnosed Patient LM with thoracic and lumbar disk disease, bulging cervical disk, and cervical radiculopathy disease, which Respondent contended warranted medication for chronic back pain, and noted that Dr. Munzing did not mention that Patient LM suffered from such conditions. Thus, Patient LM had been dealing with chronic pain for years before Respondent began treating her. However, Respondent stated at hearing that the standard of care did not require him to refer Patient LM to a pain specialist, because her pain was being managed appropriately. Additionally, the standard of care did not require him to refer Patient LM to physical therapy, because physical therapy would not have benefitted her, because she had a progressive disease (i.e., osteoarthritis).

69. Respondent also noted that Dr. Munzing did not reference Respondent's March 26, 2013 progress note concerning his treatment of Patient LM, which Respondent contended contradicted Dr. Munzing's general criticisms of Respondent's charting and actions. Specifically, Respondent's March 26, 2013 progress note stated that Patient LM's chief complaint was right arm pain that traveled from her hand, and was heading to her shoulder. Patient LM rated her pain 9 out of 10 on the pain scale. Respondent performed a general examination that focused on Patient LM's extremities and wrote, though fairly illegibly, that Patient LM was not fully able to move her arm due to pain and had a decreased range of motion due to wrist pain. Respondent diagnosed Patient LM with right tendonitis, referred Patient LM for an x-ray of her wrist, and prescribed Tramadol, which is a lower potent medication, prednisone, which is a steroid, and a splint for her right arm. Dr. Galindo countersigned the note. On April 18, 2013, Patient LM came in to see Respondent for a follow-up visit. Respondent noted that Patient LM had tried the Prednisone, the Tramadol, and Baclofen, which is a muscle relaxant, but Patient LM's pain was not relieved. . Respondent diagnosed her with shoulder osteoarthritis and wrist pain, and referred Patient LM to an orthopedist to manage those conditions better. Respondent explained at hearing that he also diagnosed Patient LM with hypertension and anxiety, which were managed well with medications.[8]

70. With respect to Dr. Munzing's criticism of Respondent regarding the documentation of Patient LM's past medical history, Respondent explained that Patient LM's past medical history was documented throughout her chart, and that the standard of care did not require him to recopy notes from previous notes into his current notes. Respondent further disagreed that his progress notes were too brief as Dr. Munzing had criticized. Based on Respondent's experience working at clinics, particularly at Perez Medical Clinic, patients

[8] The notations concerning these diagnoses were virtually illegible.

primarily came from low socio-economic backgrounds and were charged less for medical services. Consequently, in order to sustain the business, providers had to see more patients. As such, providers at Perez Medical Clinic were expected to write only pertinent notes regarding each patient, as it was not feasible for him or other providers to write notes with the kind of specificity that Dr. Munzing described, given the volume of patients they were required to see. Respondent contended that his progress notes regarding his patients, including LM, GW, and SF, were on par with progress notes prepared by other clinic providers.

71. Overall, Respondent explained that his progress notes concerning Patient LM properly documented her pain, as evidenced by what was listed in the chief complaint sections, his examinations, such as range of motion tests, his observations, and his referrals for imaging and to an orthopedist. He further contends Patient LM's pain was stable and managed appropriately, as her pain medications were not increased, and laboratory results showed that Patient LM's kidney and liver enzymes remained normal. Additionally, Patient LM never presented with any addiction issues or drug-seeking behaviors, so there was no need to state anything regarding these issues, and explained that the standard of care did not require him to review Patient LM's CURES report. Respondent also explained that he disagreed that his notes failed to state why Patient LM received pain medication on a continual basis, as the records shows that the pain medication was controlling the pain. Respondent believed that any other physician looking at the notes would understand why opioids were routinely prescribed. Respondent also explained that he discussed the risks and benefits with Patient LM and his other patients regarding controlled substances. He told them the medications were dangerous and addictive, and also told them not to take the medication and consume alcoholic beverages. Respondent disagreed with Dr. Munzing that the standard of care required that he give his patients informed consent documents regarding the dangers of controlled substance medications.

72. Respondent also contends that, overall, his progress notes concerning Patient LM's hypertension were sufficient, as they included Patient LM's blood pressure readings, and they showed that Respondent maintained her medications that had been prescribed to her previously, which kept Patient LM's blood pressure stable. Respondent contends that a provider could look at his progress notes and understand what was going on with Patient LM regarding her hypertension. Similarly, with respect to Patient LM's anxiety, Respondent explained that he would routinely ask questions about how she was doing and whether she had any worries. He stated that if Patient LM had revealed any stressors, he would have listed them.

73. Respondent disagreed with Dr. Munzing that he did not order laboratory tests or monitor Patient LM's treatment appropriately. On December 17, 2013, for example, Respondent's progress note showed that he had written down the laboratory results that he reviewed, which prompted him to decrease Patient LM's pain medication. Specifically, the laboratory results showed that Patient LM's liver enzymes were negatively impacted, which prompted Respondent to decrease Patient LM's acetaminophen that she had been taking.

Respondent had also ordered an ultrasound of Patient LM's upper quadrant to scan Patient LM's liver, and also ordered a hepatitis panel.

74. Given the above factors, Respondent contended he engaged in no unprofessional conduct concerning Patient LM, despite Complainant's charges to the contrary.

B. PATIENT GW

75. Respondent explained that Patient GW had been a patient of the clinic since 2006, and had been in a severe accident, which resulted in a thoracic plate in his back and a shortened right leg. Patient GW had a rod in his leg to address a leg injury, which resulted in Patient GW overcompensating in the way that he walked and moved. The overcompensation contributed to the pain Patient GW experienced. Additionally, Patient GW suffered lower lumbar spine issues stemming from the narrowing of his L4-5 and L5-S1 disk spaces, which contributed to his pain. Respondent testified that the standard of care did not require him to refer Patient GW to physical therapy; he would not have benefitted from physical therapy because he had a progressive illness.

76. Patient GW also suffered seizures. Beginning in 2006, Dr. Oscar Perez treated Patient GW's seizures with Klonopin. On April 16, 2009, Patient GW came to Perez Medical Clinic for a visit with Dr. Oscar Perez. The progress note on that date indicated that "only Klonopin works." (Exhibit 9, p. AGO 410.)

77. Respondent first saw Patient GW on November 1, 2012, and explained that it was his practice to review the previous progress note, which was June 4, 2010, and have a discussion with Patient GW. Respondent performed a well-adult examination on Patient GW and noted, among other things, that Patient GW had tenderness to palpation in the lumbar spine area, and walked with a cane. Respondent contends that his physical examination and documentation were within the standard of care, but acknowledged that his note was silent as to the level of Patient GW's pain.

78. During the November 1, 2012 visit, Respondent diagnosed Patient GW with chronic lower back pain, and depression based on what Patient GW told him; however, Respondent acknowledged he listed nothing about what Patient GW had shared with Respondent about his level of depression, or the reasons behind Patient GW's depression. Respondent's plan was for Patient GW to continue with his medications, including Vicodin for pain and explained that he continued Patient GW on Klonopin to help him with his depression, as well as with his seizures. At hearing, Respondent testified that he discussed with Patient GW the risks and benefits of using dangerous controlled substances, and stated that the standard of care did not require him to refer Patient GW to a pain specialist, because his pain was being managed appropriately. However, he acknowledged that Klonopin, which is a benzodiazepine, was not the best medication for depression, and that a selective serotonin reuptake inhibitor (SSRI) generally treated depression better.

79. On November 12, 2012, Respondent signed a form ordering Patient GW contoured back support, a cane, knee support, and a heating pad.

80. Respondent explained that while Dr. Munzing concluded that Patient GW could have been an addict because he visited a methadone clinic, Respondent never witnessed Patient GW engage in any drug-seeking behavior, or otherwise demonstrate that he was an addict. However, at hearing, Respondent testified that had he known Patient GW had been a patient of a methadone clinic, he would have changed the way he treated Patient GW after first seeking guidance from his supervising physician.

81. On June 21, 2013, Respondent saw Patient GW, and during his physical examination of Patient GW, measured Patient GW's legs and noted that Patient GW's right leg was shorter than his left leg. Consequently, Respondent referred Patient GW to a podiatrist to obtain a heeled shoe. Additionally, Respondent diagnosed Patient GW with hypertension, depression, and anxiety. Respondent continued Patient GW on Klonopin, because he concluded that it was medically warranted to control Patient GW's seizures, and contended the medical record was clear for why Patient GW needed Klonopin. However, Respondent's progress note mentioned nothing about seizures.

82. On July 3, 2014 and September 2, 2014, Respondent saw Patient GW, who came into the clinic for refills of his medications. The progress note stated that Patient GW felt well at the July 3, 2014 visit, but suffered body aches at the September 2, 2014 visit. Respondent diagnosed Respondent with chronic lower back pain, hypertension, tobacco use, and hyperlipidemia. Respondent explained at hearing that there was no need to include any information concerning Patient GW's lower back pain or hypertension, because Patient GW had a long history of the two based on prior notes. However, with respect to the hyperlipidemia diagnosis, Respondent's progress notes indicated that he told Patient GW to eat oatmeal and less cheese and eggs. Respondent contended his progress notes were sufficient and within the standard of care.

83. Overall, Respondent contended that his progress notes concerning Patient GW included sufficient information, and believed that any knowledgeable provider looking at his notes would have known what was going on with Patient GW. Respondent also explained that the standard of care did not require him to include more information in his progress notes regarding Patient GW's seizures, because the seizure history followed Patient GW from provider to provider, and he was not required to document anything else about the seizures unless something was happening concerning the seizures. Additionally, Respondent acknowledged that he listed nothing in any of his progress notes regarding the specifics of Patient GW's depression and anxiety, but stated that had any red flags appeared concerning Patient GW's depression or anxiety, particularly anything suggesting they were not being managed well or that the medications were no longer working, he would have noted and addressed it.

84. Given the above factors, Respondent contended he engaged in no unprofessional conduct concerning Patient GW, despite Complainant's charges to the contrary.

C. PATIENT SF

85. Respondent explained that when Patient SF came into the clinic on October 14, 2014 for a physical examination and to address his right shoulder pain, Respondent performed a complete medical examination, and found that everything appeared normal, except for the right shoulder pain and his slightly elevated blood pressure. Respondent stated that during the examination of Patient SF's shoulder, he would have tested the range of motion by asking Patient SF to raise his arm and Respondent would have palpated the area. However, in the video of the examination, Respondent did not ask Patient SF to raise his arm and his progress notes did not reflect that he had palpated the area. Additionally, the video did not depict him performing a full physical examination. Rather, as depicted in the video, the bulk of the visit focused on Patient SF's pain, in which Patient SF stated twice that he had received Norco from a friend, and then requested Respondent to prescribe him some Norco. Respondent neither questioned nor explained the illegality of Patient SF receiving Norco from his friend, and did not conclude that Patient SF had engaged in any drug-seeking behavior by specifically requesting the Norco. Instead, Respondent concluded from his examination that a prescription for Norco, with no refills, was warranted. Respondent also concluded that referring Patient SF for an MRI was warranted in order to determine whether Patient SF had any soft tissue injuries.

86. Overall, Respondent contended that his treatment of Patient SF and his progress notes were within the standard of care.

87. Given the above factors, Respondent contended he engaged in no unprofessional conduct concerning Patient SF, despite Complainant's charges to the contrary.

D. MITIGATION / REHABILITATION

88. Respondent has practiced as a physician assistant since 2001, and has no record of prior discipline imposed by the Board.

89. In addition to the certificate of completion Respondent earned regarding a controlled substances education course on January 24, 2009, on October 22, 2017, Respondent completed a prescribing course presented by the School of Medicine at the University of California, Irvine. The course focused on opioids, pain management, and addiction.

90. After learning of Dr. Munzing's criticisms regarding the manner in which Respondent documented progress notes, among other things, Respondent prepared a comprehensive chart or progress note template to address those criticisms. Specifically, the

template included entries concerning patients' pain level (i.e., a pain scale), type of pain, effects of pain, CURES information, mental health information, specialists involved, comprehensive examination findings, urine drug screen results, laboratory results, patient education information, and referral information, among other things. Respondent believes providers, including himself, can use the template for future patients to ensure more comprehensive notes.

Credibility Findings[9]

91. Dr. Munzing was a credible and persuasive witness, as he testified in a clear, comprehensive, and concise manner, and demonstrated his wealth of pertinent knowledge in the area of pain management and record keeping, buttressed by his more than 30 years of experience practicing family medicine, teaching and training medical students, and treating thousands of patients. Additionally, Dr. Munzing has demonstrated expertise in the area of opioids, evidenced by his numerous presentations and his peer-reviewed publication on the subject. Dr. Munzing's testimony was persuasive with respect to establishing what acts and performances fell within the standard of care, and how his review of the medical records

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[9] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

established that Respondent, in a number of instances, failed to operate within the standard of care. Overall, Dr. Munzing's testimony was afforded great weight.

92. Respondent, too, testified in a clear and straightforward manner, and demonstrated knowledge based on his more than 10 years of practice, his clinical experience, and from seeing 40,000 to 60,000 patients over the course of his career. However, Respondent's experience did not outweigh that of Dr. Munzing, who has been practicing for more than two decades longer than Respondent, and who has acquired a great wealth of knowledge in the areas pertinent to this matter. As such, Dr. Munzing's testimony was afforded more weight than Respondent's.

Character Evidence

93. Respondent submitted letters of recommendation from several individuals who had written letters in support of Respondent's efforts to obtain employment in 2008 and 2013. Specifically, Shelley Dolkas, a lead physician assistant at St. Jude Medical Center (St. Jude), wrote a letter dated April 14, 2008 describing Respondent's qualities as physician assistant in the emergency department. Ms. Dolkas stated that Respondent "took excellent patient histories—very thorough and complete," that patients felt comfortable with Respondent, and that he was reliable and easy with whom to work. (Exhibit D, p. 1.) The letter included no indication that Ms. Dolkas was aware of the instant disciplinary proceedings initiated against Respondent.

94. Ansen Lam, M.D., an attending physician in St. Jude's emergency department, wrote a letter on April 25, 2008, stating that Respondent's clinical acumen was excellent. Dr. Lam stated that Respondent he had good decision-making and procedural skills (e.g., placement of splints, sutures, and reductions), a good rapport with staff and patients, and had shown "an extremely high level of dedication, motivation, and hard work." (Exhibit D, p. 2.) The letter included no indication that Dr. Lam was aware of the instant disciplinary proceedings initiated against Respondent.

95. Timothy G. Greco, M.D., an attending physician in St. Jude's emergency department, wrote a letter on May 5, 2008, stating that Respondent's workups were "complete and appropriate," and that he "presented findings and complaints appropriately" to Dr. Greco. (Exhibit D, p. 3.) Dr. Greco also stated that Respondent was able to work independently, and had good diagnostic skills. The letter included no indication that Dr. Greco was aware of the instant disciplinary proceedings initiated against Respondent.

96. Mona Shah, M.D., a physician at Prime Medical, wrote a letter on October 21, 2013, lauding Respondent's determination, concentration, and willingness to work hard. Dr. Shah also stated that Respondent possessed "excellent patient care abilities, professional work ethic, a good team attitude and a great passion for the primary care of [their] patients." (Exhibit D, p. 4.) Dr. Shah further stated that Respondent had the "skills, knowledge and experience to realize, manage and triage urgent/emergent conditions in adult patients." (*Id.*)

The letter included no indication that Dr. Shah was aware of the instant disciplinary proceedings initiated against Respondent.

97. Editte Gharakhanian, PhD, professor of biological sciences at California State University at Long Beach, submitted a January 10, 2017 letter to the Board concerning Respondent's character and abilities. Specifically, Dr. Gharakhanian, who served as Respondent's professor from Fall 1990 to Fall 1993 in three separate biology classes, stated that Respondent, who served as her undergraduate research student, was responsible, dependable, honest, and operated with integrity and in an ethical manner. Additionally, Dr. Gharakhanian stated that Respondent was able to conduct research level analysis of molecular biology literature, analyze complex problems, follow appropriate scientific protocols, work well with other molecular biology students, and work on multiple molecular biology systems. The letter included no indication that Dr. Gharakhanian was aware of the instant disciplinary proceedings initiated against Respondent.

98. Roy Guizado, MS, PA-C, DFAAPA, chair of the Department of PA Education at the College of Allied Health Professions, submitted a November 30, 2016 letter stating that during Respondent's tenure at Western University of Health Sciences from 1999 to 2001, Respondent exhibited no issues with his professional conduct or professionalism, and always showed due respect to his faculty and fellow students. The letter included no indication that Mr. Guizado was aware of the instant disciplinary proceedings initiated against Respondent.

Costs of Prosecution

99. The Board incurred investigation costs in the amount of $6,450, and prosecution costs the amount of $28,032.50, for total costs of $34,482.50. These costs are reasonable pursuant to Business and Professions Code section 125.3.

CONCLUSIONS OF LAW

Parties' Contentions

1. Complainant contends that Respondent: (1) engaged in acts or omissions constituting gross negligence in connection with his care and treatment of Patients LM and GW, as he committed extreme departures from the standard of care, in violation of Business and Professions Code section 2234, subdivision (b); (2) committed repeated acts of negligence with respect to Patients LM, GW, and SF, in violation of Business and Professions Code section 2234, subdivision (c); (3) prescribed dangerous drugs to Patients LM, GW, and SF without an appropriate prior examination or medical indication therefor, in violation of Business and Professions Code section 2242, subdivision (a); (4) excessively prescribed dangerous drugs to Patients LM, GW, and SF, in violation of Business and Professions Code section 725, subdivision (a); (5) maintained inadequate and inaccurate records of his care and treatment of Patients LM, GW, and SF, in violation of Business and

Professions Code section 2266; (6) prescribed controlled substances to Patient GW who had signs of addiction, in violation of Business and Professions Code section 2241; (7) provided medical services to Patients LM, GW, and SF without proper supervision, in violation of Business and Professions Code section 3502, subdivision (a); and (8) administered controlled substances to Patients LM, GW, and SF without advance approval by a supervising physician, in violation Business and Professions Code section 3502.1, subdivision (c)(2).

2. Respondent disagrees and contends that he engaged in no unprofessional conduct, as his care and treatment of Patients LM, GW, and SF fell within the standard of care, and that he managed their care appropriately.

The Applicable Law

3. Pursuant to Business and Professions Code section 3527, subdivision (a), the Board may discipline the license of a licensee who engages in "unprofessional conduct" in violation of the Physician Assistant Practice Act (Bus. Prof. Code, § 3500 et seq.), the Medical Practices Act (Bus. & Prof. Code, § 2000 et seq.), the Board's regulations, and the regulations of the Medical Board of California.

4. Business and Professions Code section 2234 provides, in pertinent part, the following:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> [¶] ... [¶]
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> [¶] ... [¶]

5. "Gross negligence" has been defined as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

6. A lack of ordinary care defines negligent conduct. A "negligent act" as used in Business and Professions Code section 2234 is synonymous with the phrase, "simple

departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

7. Business and Professions Code section 2242, subdivision (a), provides the "[p]rescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

8. Business and Professions Code section 725 provides, in pertinent part, the following:

> (a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.
>
> [¶] ... [¶]
>
> (c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.
>
> [¶] ... [¶]

9. Business and Professions Code section 2266 provides that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. Business and Professions Code section 2241 provides as follows:

> (a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.
>
> (b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for the purposes of maintenance

on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d) (1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or mor of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

11. Business and Professions Code section 3502, subdivision (a), provides as follows:

> (a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

12. Business and Professions Code section 3502.1 provides, in pertinent part, the following:

> (a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).
>
> [¶] ... [¶]
>
> (2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

[¶] ... [¶]

(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

[¶] ... [¶]

(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried

out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

[¶] ... [¶]

Analysis of Charges

A. GROSS NEGLIGENCE CHARGE[10]

13. Complainant persuasively established that Respondent engaged in acts or omissions constituting gross negligence in connection with his care and treatment of Patients LM and GW, as he committed extreme departures from the standard of care, in violation of Business and Professions Code section 2234, subdivision (b). Specifically, the evidence, coupled with the credible testimony of Dr. Munzing, demonstrated that Respondent generally failed to document adequate and appropriate histories in the progress notes/records, as well as document adequate physical examinations, prior to prescribing and/or refilling controlled substances for Patients

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[10] Paragraphs 17 and 19 of the Accusation each allege 23 separate factors constituting gross negligence concerning Patients LM and GW, respectively. Because it is unnecessary to establish every single factor in order to determine whether Respondent has acted with "the want of even scant care," (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052), this decision will highlight only some of the alleged failures in this section, and will discuss others in some of the remaining sections below.

LM and GW. Of the 17 office visits Patient LM had with Respondent, the above-referenced failures appeared in Respondent's progress notes of November 10, 2014, September 16, 2014, July 16, 2014, October 18, 2013, June 25, 2013, May 17, 2013, April 18, 2013, March 26, 2013, February 7, 2013, December 17, 2012, November 15, 2012, October 12, 2012, and September 20, 2012 (i.e., 13 of them). Similarly, of the 13 office visits Patient GW had with Respondent, the above referenced failures appeared in Respondent's progress notes of September 2, 2014, November 1, 2012, July 3, 2014, April 8, 2014, February 10, 2014, December 12, 2013, October 17, 2013, September 12, 2013, June 21, 2013, April 22, 2013, January 24, 2013, and December 20, 2012 (i.e., 12 of them). In short, Respondent's progress notes were extremely brief and, according to Dr. Munzing, "of no value in understanding the reason for the visit," and devoid of the rationale for prescribing controlled substances. (Exhibit 27, p. AGO 877.)

14. Additionally, Complainant established, through the credible testimony of Dr. Munzing, based, in part, on his references to prescribing specifics and guidelines published by the Medical Board of California, that Respondent was required to obtain a thorough history, updated history, and perform an appropriate examination at every visit before prescribing dangerous medications. However, Respondent failed to do so, evidenced by the absence of such information in his progress notes concerning Patients LM and GW.

15. Moreover, Complainant established that Respondent, in prescribing opioids/controlled substances to Patients LM and GW, failed to include in his progress notes a treatment plan, a discussion of treatment goals, a functional assessment, and ongoing monitoring. Overall, due to the lack of documentation in Respondent's progress notes, he failed to provide justification for prescribing opioids/controlled substances. Additionally, the credible testimony of Dr. Munzing established that Respondent's apparent failure to discuss the major potential risks of controlled substances with Patients LM and GW, evidenced by the lack of documentation in the progress notes/records of the same, posed a danger to Patients LM and GW. For years Respondent prescribed dangerous prescriptions to LM and GW for years, including opioids and benzodiazepine medications, the combination of which, as central nervous system depressants, heightened the potential dangers to them.

16. Particularly troubling is Respondent prescribing of opioids to Patient GW, despite an October 29, 2012 notation in his records indicating that Patient GW had been a patient of a methadone clinic. Such action potentially placed Patient GW in great danger, as methadone, according to Dr. Munzing, is a long-acting opioid medication that blocks the opioid receptor. Therefore, if someone is on methadone and then takes more opioids, that person could die of an overdose. As such, Dr. Munzing explained that a physician should never prescribe an opioid to a methadone patient. However, Respondent prescribed opioids to Patient GW on 13 occasions, the first occasion just three days following the October 29, 2012 notation, simply because

Patient GW sought refills and because other providers at Perez Medical Clinic had done the same. Respondent, apparently, failed to conduct his own independent analysis. At hearing, when challenged with the danger in which Respondent placed Patient GW, Respondent, while asserting that he had never witnessed Patient GW engage in drug-seeking behavior, acknowledged that had he known Patient GW had been a patient of a methadone clinic, he would have changed the way he treated Patient GW.

17. The above-referenced failures on Respondent's part constituted an extreme departure from the standard of care, individually and collectively, according to the persuasive testimony of Dr. Munzing. Specifically, they demonstrated "the want of even scant care" on Respondent's part, given Respondent's overall and repeated failure to attend to the most basic level of detail in the care and treatment of his patients, particularly those he has prescribed controlled substance medications. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) Given these factors, Complainant persuasively established that Respondent engaged in gross negligence in his care and treatment of Patients LM and GW, in violation of Business and Professions Code section 2234, subdivision (b).

18. Respondent, however, contends he committed no gross negligence, as he believed that any other provider reviewing his notes would have understood what was going on with his patients at any given time. Specifically, Respondent asserts that his progress notes properly documented Patients LM's and GW's pain, as evidenced by what was listed in the chief complaint sections, his examinations including his range of motion tests, his observations, and his referrals for imaging and to an orthopedist or podiatrist. He further contends Patients LM's and GW's pain was stable and managed appropriately, as their pain medications were not increased, and laboratory results in Patient LM's case showed that her kidney and liver enzymes remained normal. Additionally, Patients LM and GW, according to Respondent, never presented with any drug-seeking behaviors, so he contends there was no need to state anything regarding these issues. Moreover, Respondent asserts that he did, in fact, explain that he discussed the risks and benefits with Patients LM and GW regarding controlled substances, as he did with all of his patients taking controlled substances. Finally, Respondent argues that his progress notes fell within the standard of care, particularly for those created in a clinic setting which, according to Respondent, did not require the level of detail described by Dr. Munzing.

19. However, Respondent's assertions do not align with the evidence. While Respondent contends that his progress notes included enough detail for a provider to review them and understand what was going on with his patients at any given time, Respondent could not explain in his June 15, 2012 note concerning Patient LM, for example, the current status of Patient LM's back issues, which he acknowledged at hearing was important to know before prescribing controlled substances. Additionally, Respondent acknowledged that his note was silent on whether he had a conversation with Patient LM regarding her anxiety, the level of her

anxiety, and the date of her last panic attack, yet he prescribed a controlled substance to address her anxiety. Similarly, in a November 1, 2012 note concerning Patient GW, for example, Respondent diagnosed Patient GW with chronic lower back pain and depression based on what Patient GW told him; however, Respondent acknowledged he listed nothing about what Patient GW had shared with Respondent about his level of depression, or the reasons behind Patient GW's depression. While these are only two examples, they represent the skeletal nature of the bulk of Respondent's progress notes, thereby leaving providers like Dr. Munzing questioning the status of Patients LM and GW on any given office visit. They also leave for guesswork whether Respondent did, in fact, discuss the risks and benefits with Patients LM and GW regarding controlled substances, as he has expressly represented, as these notes, as well as all of the others, omitted such information.

B. REPEATED NEGLIGENT ACTS CHARGE

20. Complainant persuasively established that Respondent committed repeated acts of negligence with respect to Patients LM, GW, and SF, in violation of Business and Professions Code section 2234, subdivision (c). With respect to Patients LM and GW, Respondent committed repeated acts of negligence, as set forth above in Legal Conclusions 13 through 17 above, are incorporated by reference. With respect to Patient SF, who presented with shoulder pain and elevated blood pressure, the evidence, coupled with the credible testimony of Dr. Munzing, demonstrated that Respondent conducted an abbreviated examination of Patient SF, but nothing in the video depicted Respondent performing a shoulder examination. Specifically, the video, including the audio portion, at no time involved Respondent directing Patient SF to raise his arm or otherwise determine Patient SF's range of motion, for example. Yet, Respondent prescribed Norco pursuant to Patient SF's specific request for the same, absent any examination information.

21. Additionally, Respondent failed to recheck and confirm Patient SF's blood pressure, and failed to take Patient SF's history about past blood pressure elevations, including family history, history of alcohol, smoking, caffeine, and salt intake. Yet, Respondent prescribed Lisinopril to Patient SF to address his blood pressure, absent any pertinent history. The evidence, specifically the credible opinion of Dr. Munzing, showed that Respondent's overall failure to appropriately evaluate and manage Patient SF's elevated blood pressure constituted a simple departure from the standard of care.

22. Given the above, Complainant persuasively established that Respondent engaged in repeated acts of negligence with respect to Patients LM, GW, and SF, in violation of Business and Professions Code section 2234, subdivision (c).

C. PRESCRIBING WITHOUT EXAM / INDICATION AND EXCESSIVE PRESCRIBING CHARGES

23. Complainant persuasively established that Respondent prescribed dangerous drugs to Patients LM, GW, and SF without an appropriate prior examination or medical indication therefor, in violation of Business and Professions Code section 2242, subdivision (a), and that he prescribed them excessively, in violation of Business and Professions Code section 725, subdivision (a). As established in Legal Conclusions 13 through 17 and 20 through 22 above, which are incorporated by reference, Respondent prescribed opioids and benzodiazepines to Patients LM and GW at nearly all of their respective appointments, which required, according to Dr. Munzing, Respondent to obtain a thorough and updated history, and to perform an appropriate examination at every visit. However, as the record has established, Respondent's progress notes in connection with those 17 and 13 visits of Patients LM and GW, respectively, were virtually silent concerning updated histories and pertinent examinations. Specifically, Respondent generally did not ask for or document clarifying information about the medical problems treated by the controlled substance medications, and, particularly with Patients LM and GW, obtained no information concerning the intensity of their pain and anxiety, or specific information concerning Patient GW's seizures and depression. Similarly, Respondent's progress note concerning Patient SF lacked any information describing the intensity of his shoulder pain, and the history related to Patient SF's elevated blood pressure. Despite these failures, Respondent prescribed controlled substance medications to Patients LM, GW, and SF anyway. Accordingly, Complainant persuasively established that Respondent violated Business and Professions Code sections 2242, subdivision (a), and 725, subdivision (a), in that Respondent prescribed dangerous drugs to Patients LM, GW, and SF without an appropriate prior examination or medical indication therefor, and prescribed them excessively without appropriate documentation to medically justify the prescribing of opioids and benzodiazepines, all of which Dr. Munzing considered extreme departures from the standard of care.

D. INADEQUATE RECORDS CHARGE

24. Complainant persuasively established that Respondent maintained inadequate and inaccurate records of his care and treatment of Patients LM, GW, and SF, in violation of Business and Professions Code section 2266. As established in Legal Conclusions 13 through 17 and 20 through 23 above, which are incorporated by reference, as well as by the weight of the evidence, Respondent failed to document an adequate history and/or physical examination while prescribing dangerous controlled substance medications, particularly to Patients LM and GW. These records also lacked documentation of any discussion Respondent claims he had with his patients regarding the potential risks of controlled substances, and lacked documentation of medically sufficient information justifying his prescribing of controlled substances to Patients LM, GW, and SF. These failures, according to Dr. Munzing, constituted an

extreme departure from the standard of care, and established a violation of Business and Professions Code section 2266.

E. PRESCRIBING TO AN ADDICT CHARGE

25. Complainant established that Respondent prescribed controlled substances to Patient GW who Respondent should have known was a patient of a methadone clinic. Business and Professions Code section 2241, subdivision (b), prohibits a provider from prescribing, dispensing, or administering dangerous drugs or controlled substances "to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose." The evidence, as well as Legal Conclusion 16, established that Respondent prescribed opioids to Patient GW for the first time on November 1, 2012, despite a notation in his records dated just a few days prior, October 29, 2012, indicating that Patient GW had been a patient of a methadone clinic. This notation placed Patient GW's providers, including Respondent, on notice that he was most likely an addict. However, due to Respondent's obvious failure to review the October 29, 2012 notation and his failure to obtain a comprehensive history from Patient GW, Respondent placed Patient GW in conceivable danger, subjecting him to a potential overdose, as a result of the 13 occasions that Respondent prescribed opioids to him. Dr. Munzing characterized these failures as extreme departures from the standard of care. Given the above factors, Respondent violated Business and Professions Code section 2241, subdivision (b).

26. While Respondent has asserted that Patient GW exhibited no drug-seeking behaviors during his office visits, this factor did not eliminate Respondent's initial duty to review Patient GW's records and obtaining an adequate history in the first place, particularly prior to treating him with opioid medications. Additionally, while Respondent never suspected Patient GW of engaging in drug abuse activities, the absence of suspicion on Respondent's part did not mean that Patient GW never engaged in such activities. Because of a lack of monitoring through CURES, for example, though not mandatory, Respondent foreclosed an opportunity to discover through CURES whether Respondent was engaged in drug-seeking behavior or not, such as doctor-shopping. Be that as it may, the bottom line is that Respondent, from the beginning, should have known about Patient GW's methadone history, and adjusted his treatment of Patient GW accordingly.

F. PROVIDING MEDICAL SERVICES WITHOUT ADEQUATE SUPERVISION CHARGE

27. Complainant persuasively established that Respondent provided medical services to Patients LM, GW, and SF without proper supervision, in violation of Business and Professions Code section 3502, subdivision (a). As established in Legal Conclusions 13 through 17 and 20 through 25 above, which are incorporated by reference, as well as by the weight of the evidence, Respondent, in essence, operated

alone at Perez Medical Clinic, despite the language of the Delegation of Services Agreement, which aligned with the language of Business and Professions Code section 3502.1, subdivision (e), providing that Respondent would be supervised in accordance with the Physician Assistant Regulations, and that the physician would review, countersign, and date within seven days the medical record of any patient treated by Respondent and who received prescriptions for Schedule II medications from him. The Delegation of Services Agreement also provided that the physician would audit the medical records of at least 10% of patients seen by Respondent under any protocols adopted by the supervising physician and Respondent. Despite the Delegation of Services Agreement, neither Dr. Galindo nor Dr. Perez reviewed, countersigned, and dated within seven days the medical record of any patient treated by Respondent and who received prescriptions for Schedule II medications from him, and Respondent took no active role in seeking out supervision to ensure compliance with the Delegation of Services Agreement. Consequently, Respondent repeatedly issued prescriptions for controlled substances without any oversight, or written formularies or protocols issued by Perez Medical Clinic, thereby potentially endangering patients. Dr. Munzing considered such failures of this shared responsibility as extreme departures from the standard of care. Given the above factors, Complainant firmly established that Respondent violated Business and Professions Code section 3502, subdivision (a).

G. ADMINISTRATION OF CONTROLLED SUBSTANCES WITHOUT ADVANCE APPROVAL BY A SUPERVISING PHYSICIAN CHARGE

28. Complainant failed to establish that Respondent is culpable of administering controlled substances to Patients LM, GW, and SF without advance approval by a supervising physician. Complainant, citing Business and Professions Code section 3502.1, subdivision (c)(2), asserted that Respondent was prohibited from administering, providing, or issuing drug orders to patients for controlled substances without advance approval by a supervising physician. However, that same statute also provides that a physician assistant can, in fact, administer, provide, or issue drug orders without advance approval, if the physician assistant has completed an education course that covers controlled substances. The evidence showed that Respondent earned a certificate of completion in a controlled substances education course on January 24, 2009, rendering him eligible to write prescriptions for controlled substances without first seeking advance approval. As such, this charge is dismissed.

Appropriate Level of Discipline

29. Complainant seeks revocation of Respondent's license, given his multiple acts of unprofessional conduct stemming from his unsupervised tenure at Perez Medical Clinic. While revocation falls into the range of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, particularly given the gross negligence involved, such discipline is not warranted in this matter. Respondent has enjoyed

a relatively long period of practice with no prior record of discipline. Additionally, in an effort to remain current on subject matter pertinent to his practice as a physician assistant, Respondent recently completed another prescribing course focusing on opioids, pain management, and addiction. Moreover, Respondent has created a comprehensive template for progress notes that address the criticisms leveled by Dr. Munzing, in an effort to improve his performance. Given these factors and in lieu of revocation, the public would be adequately protected by a period of probation, subject to terms and conditions, including adequate and appropriate supervision of physicians.

Costs

30. Under Code section 125.3, the Board may request the administrative law judge to direct a licentiate found to have committed violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. These reasonable costs are $34,482.50, as set forth in Factual Finding 99.

31. Under *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.App.4th 32, 45, the Board must exercise its discretion to reduce or eliminate cost awards so as to prevent cost award statutes from deterring licensees with potentially meritorious claims or defenses from exercising their right to a hearing. "Thus the [Board] may not assess the full costs of investigation and prosecution when to do so will unfairly penalize a [licensee] who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed." (*Id.*) The Board, in imposing costs in such situations, must consider the licensee's subjective good faith belief in the merits of his or her position and the Board must consider whether or not the licensee has raised a colorable defense. The Board must also consider the licensee's ability to make payment.

32. While Respondent did not directly challenge the costs, the procedural history in this matter showed that at least two deputies attorney general have worked on this matter and each, presumably, have billed accordingly, including time to review and become acquainted with the case. Additionally, the record established that Respondent currently works as a grocery store employee and not as a physician assistant. Given these factors, a reduction of the costs would be appropriate in this matter. As such, instead of paying the Board $34,482.50, Respondent shall pay the Board half of those costs, or $17,241.25, pursuant to a payment plan acceptable to the Board.

ORDER

Physician's Assistant License No. PA 16136, issued to Respondent Andrew Kevin Sajo, is hereby revoked. However, the revocation is stayed and Respondent is placed on probation for five years upon the following terms and conditions.

1. Approval of Supervising Physician

Within 30 days of the effective date of this decision, Respondent shall submit to the Board or its designee for its prior approval the name and license number of the supervising physician and a practice plan detailing the nature and frequency of supervision to be provided. Respondent shall not practice until the supervising physician and practice plan are approved by the Board or its designee.

Respondent shall have the supervising physician submit quarterly reports to the Board or its designee.

If the supervising physician resigns or is no longer available, Respondent shall, within 15 days, submit the name and license number of a new supervising physician for approval. Respondent shall not practice until a new supervising physician has been approved by the Board or its designee.

2. Notification of Employer and Supervising Physician

Respondent shall notify his/her current and any subsequent employer and supervising physician(s) of the discipline and provide a copy of the accusation, decision, and order to each employer and supervising physician(s) during his/her period of probation, before accepting or continuing employment. Respondent shall ensure that each employer informs the Board or its designee, in writing within 30 days, verifying that the employer and supervising physician(s) have received a copy of Accusation, Decision, and Order.

This condition shall apply to any change(s) in place of employment.

Respondent shall provide to the Board or its designee the names, physical addresses, mailing addresses, and telephone numbers of all employers, supervising physicians, and work site monitor, and shall inform the Board or its designee in writing of the facility or facilities at which the person practices as a physician assistant.

Respondent shall give specific, written consent to the Board or its designee to allow the Board or its designee to communicate with the employer, supervising physician, or work site monitor regarding the licensee's work status, performance, and monitoring.

3. Obey All Laws

Respondent shall obey all federal, state, and local laws, and all rules governing the practice of medicine as a physician assistant in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Reports

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board or its designee, stating whether there has been compliance with all the conditions of probation.

5. Other Probation Requirements

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board and probation unit informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board and probation unit. Under no circumstances shall a post office box serve as an address of record, except as allowed by California Code of Regulations 1399.511.

Respondent shall appear in person for an initial probation interview with Board or its designee within 90 days of the decision. Respondent shall attend the initial interview at a time and place determined by the Board or its designee.

Respondent shall, at all times, maintain a current and renewed physician assistant license. Respondent shall also immediately inform probation unit, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

6. Interview with Medical Consultant

Respondent shall appear in person for interviews with the Board's medical or expert physician assistant consultant upon request at various intervals and with reasonable notice.

7. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not practicing as a physician assistant. Respondent shall not return to practice until the supervising physician is approved by the Board or its designee.

If, during probation, respondent moves out of the jurisdiction of California to reside or practice elsewhere, including federal facilities, Respondent is required to immediately notify the Board in writing of the date or departure, and the date or return, if any.

Practicing as a physician assistant in another state of the United States or federal jurisdiction while on active probation with the physician assistant licensing authority of that state or jurisdiction shall not be considered non-practice.

All time spent in a clinical training program that has been approved by the Board or its designee, shall not be considered non-practice. Non-practice due to a Board ordered suspension or in compliance with any other condition or probation, shall not be considered a period of nonpractice.

Any period of non-practice, as defined in this condition, will not apply to the reduction of the probationary term. Periods of non-practice do not relieve Respondent of the responsibility to comply with the terms and conditions of probation.

It shall be considered a violation of probation if for a total of two years, Respondent fails to practice as a physician assistant. Respondent shall not be considered in violation for non-practice as long as Respondent is residing and practicing as a physician assistant in another state of the United States and is on active probation with the physician assistant licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. Unannounced Clinical Site Visit

The Board or its designee may make unannounced clinical site visits at any time to ensure that Respondent is complying with all terms and conditions of probation.

9. Condition Fulfillment

A course, evaluation, or treatment completed after the acts that gave rise to the charges in the Accusation but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of the condition.

10. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, probation costs) no later than 60 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's license will be fully restored.

11. Violation of Probation

If Respondent violates probation in any respect, the Board after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. Cost Recovery

The respondent is hereby ordered to reimburse the Physician Assistant Board the amount of $17, 241.25 within 90 days from the effective date of this decision for its investigative costs.

Failure to reimburse the Board costs for its investigation shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by Respondent shall not relieve Respondent of his responsibility to reimburse the Board for its investigative costs.

(NOTE: Most physician assistant cost recovery orders are paid on an installment plan.)

13. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. The costs shall be made payable to the Physician Assistant Board and delivered to the Board no later than January 31 of each calendar year.

14. Voluntary License Surrender

Following the effective date of this probation, if Respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request, in writing, the voluntary surrender of Respondent's license to the Board. Respondent's written request to surrender his license shall include the following: his name, license number, case number, address of record, and an explanation of the reason(s) why Respondent seeks to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion whether to grant the request or to take any other action deemed appropriate and reasonable under the circumstances. Respondent shall not be relieved of the requirements of his probation unless the Board or its designee notifies respondent in writing that Respondent's request to surrender his license has been accepted. Upon formal acceptance of the surrender, Respondent shall, within 15 days, deliver Respondent's wallet and wall certificate to the Board or its designee and shall no longer practice as a physician assistant. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a physician assistant license, the application shall be treated as a petition for reinstatement of a revoked license.

15. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. The course shall be Category I certified, limited to classroom, conference, or seminar settings. Respondent shall successfully complete the course within the first 6 months of probation.

Respondent shall pay the cost of the course.

Respondent shall submit a certification of successful completion to the Board or its designee within 15 days after completing the course.

16. On-Site Supervision

The supervising physician shall be on site at least 50% of the time Respondent is practicing.

DATE: February 20, 2018

DocuSigned by:
Carla L. Garrett
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CARLA L. GARRETT
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREW KEVIN SAJO, P.A.** **P.O. Box 661412** **Arcadia, CA 91066** **Physician Assistant License No. PA16136,** Respondent.	Case No. 950-2013-000031 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Glenn L. Mitchell, Jr. (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs.

2. On or about November 28, 2001, the Physician Assistant Board issued Physician Assistant License Number PA16136 to ANDREW KEVIN SAJO, P.A. (Respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2017, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code (Code) unless otherwise indicated.

4. Section 3527 of the Code states:

"(a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

"...

"(f) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

"(g) The expiration, cancellation, forfeiture, or suspension of a physician assistant license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license."

5. California Code of Regulations, title 16, section 1399.521 states:

"In addition to the grounds set forth in section 3527, subdivision (a), of the Code, the board may deny, issue subject to terms and conditions, suspend, revoke or place on probation a physician assistant for the following causes: (a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon..."

6. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default

has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

7. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

8. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer

dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, 'addict' means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

9. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs

were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by

imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

12. Section 3502 of the Code states in pertinent part:

"(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant."

"..."

13. Section 3502.1, subdivision (c)(2) of the Code states in pertinent part:

"A physician assistant may not administer, provide or issue a drug order for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for the particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board..."

14. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – 2 Patients)

15. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of patients L.M. and G.W.[1] The circumstances are as follows:

Patient L.M.

16. Patient L.M. (or "patient") is a fifty-seven- year-old female who treated at Perez Medical Clinic (clinic) with Respondent and other medical professionals from the clinic from about May 2012 through December 2014.[2] The key diagnoses for this patient were chronic knee pain, anxiety, hypertension, osteoarthritis, and chronic low back pain. Records indicate that from June 2012 to November 2013, Respondent wrote approximately thirty prescriptions to the patient for medications, including Hydrocodone and Alprazolam,[3] which were filled nearly monthly.

17. Respondent's prescribing of controlled substances to this patient departed from the standard of care as follows:

(a) The medical records/progress notes show no documentation of any supervision of respondent by a supervising physician(s).

(b) The history of present illness is generally absent and if present, is very briefly mentioned, never with any detail, and there were no specifics about the pain and anxiety.

(c) Past medical history was essentially absent, and no current mental health and past mental health history is included.

(d) The progress notes were extremely brief and are of no value in understanding the reason for the visit, the current and past diagnoses, including pain diagnoses, and none of the notes include any reasoning for the opioid/controlled substance prescriptions.

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[1] The patients are identified by initial to protect their privacy.

[2] These are only approximate dates, per the progress notes which were available for review. This patient may have treated at this clinic with other individuals prior to and after these dates. Most of the visits after June 2012 were with Respondent, and a few were with J. G., M.D., one of Respondent's supervising physicians at the clinic. It should also be noted that there is no documentation in the progress notes that Respondent ever discussed the patient's prescriptions or any other aspects of care of the patient with a supervising physician.

[3] Dangerous drugs with potentially addictive traits and side effects, if used improperly and/or overused.

(e) There were no questions about past imaging, consultations, management of pain, and the like.

(f) No information was obtained regarding past laboratory testing, and when lab tests were rarely obtained, abnormal results were not addressed (e.g. on the 7/8/13 visit).

(g) CURES and urine drug screens, which are vital prior to starting the patient on an opioid, were not obtained.

(h) None of the visits have an appropriate exam documented, especially of the area of pain.

(i) Vital signs, in spite of the opioids/controlled substances prescribed, often show elevated blood pressure readings, which were not addressed.

(j) The presence or absence of behavioral/psychiatric issues/addiction issues should have been inquired about in detail and documented.

(k) Pain or functional scales were never utilized.

(l) Outside past medical records were not obtained.

(m) A specific diagnosis is not documented.

(n) A specific treatment plan and goal(s) is never documented-this is needed at every visit.

(o) In spite of ongoing treatment, respondent did not obtain imaging during his management of the patient until very late during the treatment.

(p) Respondent also failed to obtain indicated consultation of ongoing symptoms (such as orthopedics, pain management, and physical medicine).

(q) Respondent also failed to attempt physical therapy and other less risky treatments (non-pharmaceutical medications/treatments).

(r) Treatment goals were never documented.

(s) Risks and benefits of the controlled substances were not documented being discussed with the patient.

(t) Legibility of the progress notes is poor.

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(u) Medical monitoring with urine drug screens and use of CURES was never documented.

(v) There was no documentation that a thorough history, updated history, and exam, were performed on the patient prior to prescribing/refilling dangerous medications to the patient.

(w) Overall, the evaluation and treatment of this patient represented an extreme departure from the standard of care as this patient was prescribed dangerous medications with little or no ongoing monitoring.

Patient G.W.

18. Patient G.W. (or "patient") is a sixty-five-year-old male who treated at Perez Medical Clinic (clinic) with Respondent and other medical professionals from the clinic from about October 2012 through December 2014.[4] The key diagnoses for this patient were chronic back pain, hypertension, hyperlipidemia, tobacco smoker, history of drug addiction (past methadone clinic), depression, seizure history, and chronic discogenic disease/chronic pain caused by a car accident in 2001. Records indicate that from June 2012 to November 2013, Respondent wrote approximately thirty prescriptions to the patient including Hydrocodone and Carisoprodol (Soma), Clonazepam (Klonopin), Diazepam, and Lorazepam.[5]

19. Respondent's prescribing of controlled substances to this patient departed from the standard of care as follows:

(a) The medical records/progress notes show no documentation of any supervision of respondent by a supervising physician(s).

(b) The history of present illness is generally absent and if very briefly mentioned, never with any detail, and there were no specifics about the pain and anxiety.

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[4] These are only approximate dates, per the progress notes which were available for review. This patient may have treated at this clinic with other individuals prior to and after these dates. Per the records, from November 2012 through December 2014, both Respondent and J. G., M.D., one of Respondent's supervising physicians, treated this patient at the clinic. It should also be noted that there is no documentation in the progress notes that Respondent ever discussed the patient's prescriptions or any other aspects of care of the patient with a supervising physician.

[5] Dangerous drugs with potentially addictive traits and side effects, if used improperly and/or overused.

(c) Past medical history was essentially absent, and no current mental health and past history is included.

(d) The progress notes were extremely brief and are of no value in understanding the reason for the visit, the current and past diagnoses, including pain diagnoses, and none of the notes include any reasoning for the opioid/controlled substance prescriptions.

(e) There were no questions about past imaging, consultations, management of pain, and the like.

(f) No specifics about the pain and seizure history were documented.

(g) No information was obtained regarding past laboratory testing.

(h) CURES and urine drug screens, which are vital prior to starting the patient on an opioid, were not obtained.

(i) None of the visits have an appropriate exam documented, especially of the area of pain.

(j) The presence or absence of behavioral/psychiatric issues/addiction issues should have been inquired about in detail and documented.

(k) Pain or functional scales were never utilized.

(l) Outside past medical records were not obtained.

(m) A specific diagnosis is not documented.

(n) A specific treatment plan and goal(s) is never documented-this is needed at every visit.

(o) In spite of ongoing treatment, respondent did not obtain imaging during his management of the patient until very late during the treatment.

(p) Respondent also failed to obtain indicated consultation of ongoing symptoms (such as orthopedics, pain management, and physical medicine).

(q) Respondent also failed to attempt physical therapy and other less risky treatments (non-pharmaceutical medications/treatments).

(r) Treatment goals were never documented.

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(s) Risks and benefits of the controlled substances were not documented being discussed with the patient.

(t) Legibility of the progress notes is poor.

(u) Medical monitoring with urine drug screens and use of CURES was never documented.

(v) There was no documentation that a thorough history, updated history, and exam, were performed on the patient prior to prescribing/refilling dangerous medications to the patient.

(w) Overall, the evaluation and treatment of this patient represented an extreme departure from the standard of care as this patient was prescribed dangerous medications with little or no ongoing monitoring.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts - 3 Patients)

20. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care of patients L.M. and G.W. above. The circumstances are as follows:

21. The facts and circumstances in the First Cause for Discipline above, are incorporated by reference as if set forth in full herein.

22. Respondent also committed repeated negligent acts in his care of patient S.F. The circumstances are as follows:

Patient S.F.

23. Patient S.F. (S.F. or "patient"), who was an undercover Board investigator, was treated by respondent at the clinic on October 14, 2014. On said date, after a brief evaluation, respondent wrote S.F. a prescription for Norco and Lisinopril, after S.F. claimed that he needed pain medication (specifically Norco) as a result of exercise. Respondent committed a simple departure from the standard of care in his treatment of S.F., by not conducting an appropriate history and exam, and by prescribing said medication to S.F., who really did not need the pain medication. Respondent's documentation of the visit was scant and showed no review by a supervising physician.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Exam/Indication- 3 Patients)

24. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed dangerous drugs to patients L.M., G.W., and S.F. without an appropriate prior examination or medical indication therefor.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing- 3 Patients)

25. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to patients L.M., G.W., and S.F.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate Records- 3 Patients)

26. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of patients L.M., G.W., and S.F.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing to an Addict-Patient G.W.)

27. Respondent is subject to disciplinary action under section 2241 of the Code in that Respondent prescribed controlled substances to G.W., a patient who had signs of substance abuse/dependency.

28. The facts and circumstances in paragraphs 18 through 19, above, are incorporated by reference as if set forth in full herein.

SEVENTH CAUSE FOR DISCIPLINE

(Providing Medical Services Without Adequate Supervision)

29. By reason of the facts set forth in the First and Second Causes for Discipline, Respondent is subject to disciplinary action under section 3502, subdivision (a) of the Code in

that he provided medical services to patients L.M., G.W., and S.F. without adequate supervision, as there is no documentation in the progress notes that Respondent ever discussed said patients' prescriptions or any other aspects of care of the patients with a supervising physician.

EIGHTH CAUSE FOR DISCIPLINE

(Administration of Controlled Substances Without Advance Approval By a Supervising Physician)

30. By reason of the facts set forth in the First and Second Causes for Discipline, Respondent is subject to disciplinary action under section 3502.1, subdivision (c)(2) of the Code for prescribing/administering controlled substances to patients L.M., G.W., and S.F. without advance approval by a supervising physician.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board issue a decision:

1. Revoking or suspending Physician Assistant License Number 16136, issued to Andrew Kevin Sajo, PA;

2. Ordering Andrew Kevin Sajo, P.A. to pay the Physician Assistant Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Ordering Andrew Kevin Sajo, P.A. to pay the Physician Assistant Board the costs of probation (if placed on probation), pursuant to Business and Professions Code sections 3527, subdivision (f);

4. Ordering Andrew Kevin Sajo, P.A. to pay fines and other penalties, pursuant to Business and Professions Code section 725; and

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5. Taking such other and further action as deemed necessary and proper.

DATED: May 10, 2016

GLENN L. MITCHELL, JR.
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

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